



ALL SEASONS
CHIROPRACTIC

Personal Injury Questionnaire

Services provided by Trevor Winzowski Chiropractic Corp.

185a Stone Bridge Crossing, Steinbach, MB R5G 2J2

Telephone 204-326-5800 Fax 204-346-1076

CLAIM # _____

Last name _____ First Name _____ Date of Birth _____

Today's Date: _____ Date of Collision: _____
(M/D/YY) (M/D/YY)

List primary complaints/injuries that developed as a result of the motor vehicle accident:

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Describe the accident in your own words:

I was: The driver A Front Passenger A Rear Passenger A Pedestrian A Cyclist

Area of Impact Front Drivers side Passengers side Back

Did the Airbag go off? Yes No

Did you strike anything in the vehicle? _____

Did you lose consciousness? Yes No Did you go to the hospital? Yes No

Have you lost time from work because of these injuries? Yes No

If yes, how much time off? _____ Current work status? Full Duties Modified duties Not at work

Have you experienced injuries similar to those noted above within the past 2 years of this accident? (describe) _____

Within the past 2 years of this accident:

- | Yes | No | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | 1. Have you had a previous MPI claim or WCB elected motor vehicle accident claim? |
| <input type="checkbox"/> | <input type="checkbox"/> | 2. Has your function or mobility been significantly impacted by arthritis? |
| <input type="checkbox"/> | <input type="checkbox"/> | 3. Have you undergone any treatment for cancer or other significant illness? |
| <input type="checkbox"/> | <input type="checkbox"/> | 4. Have you received supportive care (such as palliative care, etc.)? |
| <input type="checkbox"/> | <input type="checkbox"/> | 5. Have you been under active treatment for psychiatric or psychological conditions? |
| <input type="checkbox"/> | <input type="checkbox"/> | 6. Have you had any significant injuries that may affect your recovery from this accident? |

What injuries and how were you injured? _____

Have you seen any other healthcare providers for these injuries? Yes No

If yes, who? And when? _____

I hereby authorize the release of information and reports pertaining to these injuries to MPI for the duration of this claim:

Signature of Patient or Guardian

Date (M/D/YY)